VOLUNTEER ADVOCATES FOR SENIORS PROGRAM

CASE INTAKE REFERRAL INFORMATION FORM

This document is confidential. This is not a legal document and will remain at the VASIA Office.

REFERRAL SOURCE: Referral Date: _____

_____ _____

Healthcare Facility Street Address City Zip

_____ _____ _____

Social Worker/Case Manager Telephone # E-mail Address

CLIENT INFORMATION:

_____ _____ _____

First Name Middle Name Last Name

Birth Date:_____ Age:_____ SS#:_____

Medicare #: _____ Medicaid #: _____

Current Address:_____

Street Apt. Number

_____

City State Zip Code

Home Telephone #:_____ Cell Phone #:_____

Marital Status:_____ Spouse/Partner's Name:_____

Spouse / Partner's Address: _____

_____

City State Zip Code

Spouse / Partner's Telephone: _____ Cell #: _____

CURRENT SITUATION:

Facility & Room #:_____ Physician:_____

Date Admitted:_____ SW/Case Manager:_____

Medical Condition(s):_____

_____

In your professional opinion, why is there a need for a guardianship? Required

Date Diagnosed:_____ By:_____

FAMILY / FRIENDS CONTACT INFORMATION

Relatives: 1. _____
Name

_____
Address

_____ _____
Telephone # Relationship to Client

2. _____
Name

_____
Address

_____ _____
Telephone # Relationship to Client

Friends/ Other Contacts:

1. _____
Name

_____
Address

Telephone # Relationship to Client

Comments:

2. Name

Address

Telephone # Relationship to Client

Comments:

Additional Case Information:

VAS Program Office Use Only

CASE NAME: CAUSE #:

COURT: COURT ORDER DATE:

VAS VOLUNTEER: DATE ASSIGNED:

15 Day Report Due: Submitted:

60 Day Report Due: Submitted:

Inventory / Appraisement Due: Submitted:

Guardian of Estate: Attorney:

Case Extension Filed:

Extension Report(s):

VAS Removal Filed: Case Closed:

Case/Client Disposition: